	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395756			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/18/2023		
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE: 1950 CLIFFSIDE DRIVE STATE COLLEGE, PA 16801					
S (X4)HD ICENS PREFIX TAG						SHOULD BE COMPLETE		
F 0000 F 0558 SS=D	Based on a Medicare R Licensure Survey, and Survey, completed on I determined that Junipe Brookline-Rehabilitation in compliance with the CFR Part 483, Subpart Term Care and the 28 I Pennsylvania Long Ter Regulations.	Civil Rights Compli May 18, 2023, it was r Village at on and Skilled Care following requirements for B, Requirements for PA Code, Commonwant Care Licensure	was not ents of 42 r Long wealth of	F 0558				
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 1 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395756			<u></u>	05/18/2023	
JUNIPER '	VIDER OR SUPPLIER: VILLAGE AT NE-REHABILITATION A	ND SKILLED	STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OI FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0558	Continued from page 1			F 0558			
SS=D	483.10(e)(3) Reasonable Ad Needs/Preferences §483.10(e)(3) The right to refacility with reasonable account preferences except when the althor safety of the resident this REQUIREMENT is not safety of the resident to the resident that the resident	eside and receive service ommodation of resident n to do so would endang ent or other residents.	needs		- Call Bells placed within re Residents 7, 22, and 28. - The Director of Wellness of Designee will conduct initial Improvement (QI) monitorin Bell accessibility to ensure c are within reach and accessible. - The Director of Wellness of designee will reeducate staff bell accessibility. - The Director of Wellness of Designee will conduct Qualit Improvement (QI) monitorin residents accessibility of call per week x2, then weekly x3 monthly x 2. Further recommendations will be rep Quality Assurance Performa Improvement (QAPI)	or I quality ag of Call call bells ble. or on call or ty ag of I bells 5x t, then	Completion Date: 06/21/2023 Status: APPROVED Date: 05/31/2023

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 2 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	ΕY
		395756		B. WING:		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S TX4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0558	Continued from page 2		F 0558				
SS=D	Based on observation a interview, it was detern accommodate resident accessibility to a call be reviewed (Residents 7, Findings include: Interview and observat 15, 2023, at 11:17 AM lying in bed and requespillows as she was unceasked the resident to right resident could not reach hanging over the bedrat touching the floor. The to hold it in place. The bell and Employee 5, I promptly answered the her reach. In addition, used for the television the call bell. This remainightstand out of the resident	nined that the facility needs regarding the ell for three of 16 respectively. 22, and 28). The second of the resident 28 revealed the resident steed the surveyor fluor omfortable. The surveyor fluor omfortable and the call bell and the it. The call bell was in the right side as the surveyor activated as the rewas nothing on the surveyor activated and placed the remote control to also has a button to a tote was in Resident 20 the remote control to a tote was in Resident 20 the remote of the resident 20 the remote control to a tote was in Resident 20 the remote control to a tote was i	y failed to sidents B on May at was ff her eveyor he as nd he call bell the call cal nurse) it within hat is activate 28's				

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 3 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395756				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE		ND SKILLED	STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENS PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0558	Continued from page 3			F 0558			
SS=D	Interview and observat 15, 2023, at 11:56 AM sitting in her wheelcha bell was on the floor of from the chair and the bell button was on the The resident was unable The surveyor informed Interview and observat 16, 2023, at 9:40 AM r sitting in her large, pad her bed. The surveyor contact staff if she need indicated she would hat could not reach her cal The surveyor informed	revealed the resident 22 revealed the resident ir next to her bed. To posite side of the bettelevision remote with the resident of the to reach either call Employee 5 at 12:1 ion with Resident 7 revealed the resident ded wheelchair at the asked her how she with the to scream because I bell as it was on her	on May was te foot of would ident 7 e she or bed.				
	The surveyor informed Employee 5 at 9:28 AM During an interview with the Nursing Home Administrator and Director of Nursing on May 2023, at 3:10 PM the above concerns regarding						

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 4 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395756				05/18/2023	
JUNIPER '	VIDER OR SUPPLIER: VILLAGE AT NE-REHABILITATION A	ND SKILLED	STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0558	Continued from page 4		F 0558				
SS=D	Residents 7, 22, and 28 bells was discussed. 28 Pa. Code 211.12(d)						
F 0607	2014. Code 211.12(d)(1)(d) 1 (d) sing set vices			F 0607			
SS=D							

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 5 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756		B. WING:		05/18/2023	
NAME OF PROVIDER OF JUNIPER VILLA BROOKLINE-RICARE		ND SKILLED	STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENSE NUMB PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0607 Conti	inued from page 5			F 0607			
Policie \$483 policie \$483 exploi proper \$483 \$483 \$483 progra \$483 federa section must i \$483 \$483 rights,	Continued from page 5 483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement writte policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance wit section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employer rights, as defined at section 1150B(d)(3) of the Act.		and sident aph in ance with ares ements.		- References have been obtatemployee 1 and 2. - Business Office Assistant Designee will conduct initial for Quality Improvement (Q monitoring of newly hired er in past 30 days to ensure that references have been obtaine according to facility abuse p follow up based on findings. - The Nursing Home Admir will reeducate hiring manage including Human Resources Abuse Policy and reference of the Nursing Home Administration Designee will conduct Quali Improvement (QI) monitoring employees weekly x4, then references for new employees weekly x4, then reported to Quality Assurance Performance Improvement (Maintenance Impr	or I audit II) mployees t ed olicy, nistrator ers on checks. ator or ity ng of vly hired monthly x s will be ce	Completion Date: 06/21/2023 Status: APPROVED Date: 05/31/2023
define	at seedon 1150B(u)	(1) and (2) of the Act.					

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 6 of 25

PLAN OF CORRECTION (POC) IDENTIFICATION 1		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395756		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/18/2023	
JUNIPER '	VIDER OR SUPPLIER: VILLAGE AT NE-REHABILITATION A		STREET ADDRESS, 1950 CLIFFSI STATE COLL	DE DRIVE			
S (X4)HD ICENS PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0607	Continued from page 6			F 0607			
SS=D	This REQUIREMENT is no	ot met as evidenced by:					
	Parcellowninistal		Misia do Misia de Misia de Mis				
F 0744				F 0744			
SS=E							

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	.IIA (X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		395756				05/18/2023	
JUNIPER S BROOKLI CARE	VIDER OR SUPPLIER: VILLAGE AT NE-REHABILITATION A E NUMBERSU 281302 STATEMENT		STREET ADDRESS 1950 CLIFFS STATE COLI	IDE DRIVE		CTION (EACH	(X5)
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A		COMPLETE DATE
F 0744 SS=E	Continued from page 7 483.40(b)(3) Treatment/Ser §483.40(b)(3) A resident who dementia, receives the approximation or maintain his or homental, and psychosocial who this REQUIREMENT is not service.	no displays or is diagnos opriate treatment and sen her highest practicable plant ell-being.	vices	F 0744	- Person centered care plan developed and implemented Resident 38, 39, and 32. - Social Service Director or will conduct Initial Quality Improvement (QI) monitorin residents with a diagnosis of dementia and/or cognitive lo ensure that a person-centered plan to address the residents' dementia and cognitive loss been developed and implement follow up based on findings. - The Nursing Home Admin will reeducate the Social Ser Department and MDS Department and MDS Department and Cognitive loss. - Nursing Home Administrated Designee will conduct Quali Improvement (QI) monitoring residents with a diagnosis of dementia and/or cognitive loss ensure that a person-centered plan to address the residents'	Designee ag of ss to d care has ented, histrator vice timent dized s ttor or ty ag of ss to d care	Completion Date: 06/21/2023 Status: APPROVED Date: 05/31/2023

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 8 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395756		B. WING: _		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLL	DE DRIVE			
S (X4)HD ICENS PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0744	Continued from page 8			F 0744			
SS=E					dementia and cognitive loss been developed and impleme weekly x4, then monthly x 3 recommendations will be rep Quality Assurance Performa Improvement (QAPI)	ented . Further ported to	

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 9 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	XI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756		1	<u></u>	05/18/2023		
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE				
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0744	Continued from page 9			F 0744				
SS=E	Based on clinical recordit was determined that individualized approached dementia and cognitive three residents reviewed 32). Findings include: Clinical record review the facility admitted his Review of his admission Assessment (MDS, a faintervals to determine of 12, 2022, indicated that Resident 38 as having The facility determined and cognitive loss would review of Resident 38 there was no indication developed and impleming plan to address the resident record in the same plan to address the resident and cognitive loss would reveloped and impleming the plan to address the resident same plan to address the resident and cognitive loss would reveloped and impleming the plan to address the resident same plan to	the facility failed to hes to care to address to loss displayed by the displayed by the displayed by the displayed to the facility assessed the diagnosis of demand that a care plan for a care plan revealed a that the facility had ented a person-center to address the diagnosis of demand that the facility had ented a person-center to a care plan revealed a that the facility had ented a person-center to a care to address the diagnosis of demands that the facility had ented a person-center to a care plan revealed a that the facility had ented a person-center to a care plan revealed a that the facility had ented a person-center to a care plan revealed a person-center to address the care plan revealed a person-center to a care plan revealed a care plan revealed a care plan revealed a care plan revealed a care p	develop ss nree of and ealed that 022. et ecific ecember d nentia. dementia					

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 10 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395756		B. WING: _		05/18/2023		
JUNIPER	VIDER OR SUPPLIER: VILLAGE AT INE-REHABILITATION A	ND SKILLED	STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE				
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
F 0744	Continued from page 10		F 0744					
SS=E	loss that would include are focused on underst and accommodating a abilities. Clinical record review the facility admitted he Review of her admissic 2023, indicated that the 39 as having the diagnodetermined that a care cognitive loss would be Review of Resident 39 there was no indication developed and implem plan to address the resil loss that would include are focused on underst and accommodating a abilities. Interview with the Direction of the policy of the commodating a sabilities.	for Resident 39 reverser on January 22, 202 on MDS dated January are facility assessed Resonsis of dementia. The plan for dementia are developed. It's care plan revealed in that the facility had ented a person-center dent's dementia and a direct care and activated and preventing, it is a second of the preventing, it is a second of the plan for dementia and entered a person-centered dent's dementia and entered and activated and preventing, it is a second of the preventing of the preventing of the preventing of the preventing of the prevention of the preventi	relieving, loss of ealed that 23. ary 29, esident ne facility ad I that I ered care cognitive vities that relieving, loss of					

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 11 of 25

* * * * * * * * * * * * * * * * * * * *		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756		B. WING:		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0744	Continued from page 11			F 0744			
SS=E	Home Administrator o confirmed the above fi 39. Clinical record review the facility admitted he with a diagnosis include (stroke). Review of he December 6, 2022, ind that a care plan for den would be developed. It diagnosis list dated Jar Alzheimer's Disease (a and the most common added. Review of Resident 32 there was no indication developed and implem plan to address the resiloss that would include are focused on understand accommodating a strong strong and accommodating a strong str	for Resident 32 reverser on November 30, 22 ling cerebral infarction admission MDS daticated the facility dementia and cognitive Review of Resident 32 linguary 10, 2023, indicated the facility brain of the demential way 10 and the facility had ented a person-center dent's demential and edirect care and activanding, preventing, 1	ealed that 2022, on ated disease, as that ered care cognitive wities that relieving,				

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 12 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED:	
		395756				05/18/2023	
JUNIPER V				CITY, STATE, Z IDE DRIVE LEGE, PA 1			
S (X4)HD ICENS PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0744	Continued from page 12			F 0744			
SS=E	abilities.						
	Interview with the Nur						
	May 18, 2023, at 11:33 findings for Resident 3		above				
	inidings for Resident 3	۷.					
	28 Pa Code 211.12 (d)(1)(3)(5) Nursing service						
F 0825	28 Pa Code 211.11(d)	Resident care plan		F 0825			
SS=D							

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 13 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	ER:		PLE CONSTRUCTION:	(X3) DATE SURV COMPLETED:	X3) DATE SURVEY COMPLETED:	
		395756			00	05/18/2023		
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE STATHDICENSE NUMBERSU281302 STATEMENT OF DEFICIENCIES (EACH			STREET ADDRESS, 1950 CLIFFSI STATE COLI	IDE DRIVE				
S (X4)HD ICENS PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0825	Continued from page 13			F 0825				
SS=D	483.65(a)(1)(2) Provide/Ob \$483.65 Specialized rehabil \$483.65(a) Provision of ser If specialized rehabilitative to physical therapy, speech-occupational therapy, respir rehabilitative services for m disability or services of a les \$483.120(c), are required in plan of care, the facility mus \$483.65(a)(1) Provide the respectively and the services from an organized rehappear of specialized rehappear programs pursuant to service. This REQUIREMENT is not	itative services. vices. services such as but not language pathology, atory therapy, and lental illness and intellect services intensity as set forth the resident's comprehensel. equired services; or experimental with the services and is a bilitative services and is in any federal or state he ection 1128 and 1156 of	limited etual n at ensive n the s not lealth		 Resident 36 and 7 were no based on this deficient practice. Director of Rehabilitation residents, follow up based or findings. Director of Wellness or Dewill conduct initial Quality Improvement (QI) monitoring therapy referrals and evaluate ensure timely follow up. The Director of Wellness or reeducate the Rehabilitation department on specialized rehabilitation services and the offollow-up from therapy result conduct Quality Improvement (QI) monitoring of therapy reand evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4, then means and evaluations to ensure timely follow up weekly x4. 	esignee ag of ions to will meliness eferrals. esignee ement eferrals nely conthly x s will be	Completion Date: 06/21/2023 Status: APPROVED Date: 05/31/2023	

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 14 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395756			<u>uv</u>	05/18/2023	
JUNIPER V BROOKLIN CARE	VIDER OR SUPPLIER: VILLAGE AT NE-REHABILITATION A		STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENSI PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0825 SS=D	Based on clinical recordit was determined that specialized rehabilitation residents reviewed (Reference of the property of the	for Resident 36 reversal and 7). for Resident 36 reversal and 7).	ealed the 1:20 out of the room. nation was no s wellness inked to 6:00 PM	F 0825			

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 15 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 395756				IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 05/18/2023	EY	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLL	DE DRIVE			
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0825	Continued from page 15			F 0825			
SS=D	Facility documentation dated March 26, 2023, Resident 36 was self-p when she leaned forwar forehead and knees on documentation or post electronic clinical receive therapy screen referral a referral to physical the fall out of her when but was not dated until no evidence of any the for Resident 36. A wellness note for Reflection 1:00 PM noted the resident and flipped and slid to the floor with note dated April 10, 20 physical therapy consufrequent falls. A therapy screen/refer	at 5:10 PM indicating ropelling in her when and fell hitting he the floor. There was fall reports in the regarding the incident of the form was identified the reapy for frequent felchair on March 26, 1 April 13, 2023. The rapy evaluation or form was out in the latest the latest four of the was out in the latest four of the was placed for received and the result was placed for received and for the was placed for received and fell was placed fell was placed fell was placed for received and fell was placed fell	ng selchair er s no sident's ident. A indicating falls, and 2023, ere was follow up				

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 16 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		` '	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		395756		A. BLDG: _ B. WING: _		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
STX4)DICENSE NUMBERS 128/1302 STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0825 SS=D	for Resident 36 dated A registered nurse indicated falls, weakness, and will The therapy referral for therapist until May 12, who noted, "skilled occitor environmental safet management." There was up or visits with theraping 18, 2023. An interview with Emprehabilitation, confirmed any referrals or have R caseload January through therapy did not respond dated April 10, 2023, we resident has not received date. The above information Nursing Home Adminit 12:17 PM.	ting the resident had heelchair mobility corm was not signed be 2023, over 30 days cupational therapy rety and wheelchair was no evidence of a by for Resident 36, and ployee 4, senior directly did not consider the senior directly and was 12, 2023, and the senior directly did to the screening result. May 12, 2023, and sed skilled therapy single was reviewed with	frequent oncerns. y a later equired my follow s of May ctor of omplete y nat ferral and the nee that	F 0825			

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 17 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756		B. WING: _		05/18/2023		
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE		ND SKILLED	STREET ADDRESS, 1950 CLIFFSI STATE COLL	DE DRIVE				
S (X4)HD ICENS PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0825	Continued from page 17			F 0825				
SS=D								
	A physician's order dat	ted August 6, 2021, a	at 12:59					
	PM for Resident 7 reve	ealed the resident wa	s to					
	receive a regular consis	stency diet and thin l	liquids.					
	Nursing documentation	n dated April 28, 202	23, at					
	6:10 PM revealed that	Resident 7 was being	g fed					
	dinner and choked on a	•	•					
	it out of the mouth. Th							
	have lungs clear to aus	•	-					
	stethoscope) except for narrowing of airway du	*						
	like asthma) throughou							
	physician's assistant wa							
	nebulizer (a drug delive							
	medication into the lun	-						
	A therapy referral form for Resident 7 date							
28, 2023, by the nurse indicated that the re								
	coughed on corn and the	•						
	resident having the spe The therapy referral for							
	therapist on May 2, 202		_					
	inorupist on way 2, 202	25, that recommend	.u u					

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 18 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756		1		05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
STX49EDICENSE NUMBERS12841302 STATEMENT OF DEFICIENCIES (EACH I PREFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0825	Continued from page 18		F 0825				
SS=D	speech therapy assessment for dysphagia (difficult swallowing). Clinical record review for Resident 7 revealed no documented evidence of a speech therapy evaluation. During a meeting with the Nursing Home Administrator and Director of Nursing on May 16 2023, at 2:30 PM the surveyor inquired if a speech therapy evaluation was completed. A speech therapy evaluation completed on May 1 2023, revealed Resident 7 had mild oropharyngea dysphagia (swallowing problems in mouth and/or throat) that necessitated skilled speech therapy						
oral intake, develop and instruct in compenstrategies, reduce aspiration (when food/liqenters a person's airway and eventually the leading to pneumonia) with training in mansafely consume the highest level of oral intasafely swallow without signs and symptoms			uid lungs neuvers to ake and				

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 19 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395756				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLL	DE DRIVE			
S (X4)HD ICENS PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0825	Continued from page 19			F 0825			
SS=D	aspiration. An interview with Employee 4 on May 18, 2023, at 11:00 AM revealed the employee had no information as to why the speech therapy evaluation was delayed. The findings regarding the delay in Resident 7 receiving speech therapy was reviewed during an interview with the Nursing Home Administrator on May 18, 2023, at 11:50 AM.						
F 0883	28 Pa. Code 211.12(d)	(3)(5) Nursing service	ces	F 0883			
SS=D				. 5505			

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 20 of 25

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		IA (X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		395756				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
S (X4)HD ICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ID BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0883	Continued from page 20		F 0883				
SS=D	402.00/1/(1/0) 1.0					Completion	
	483.80(d)(1)(2) Influenza ar	nd Pneumococcal Immu	nızatıons		- Resident 32 and 36 evalua	ted for	Completion Date:
	§483.80(d) Influenza and pn	eumococcal immunizat	ions		and offered pneumococcal		06/21/2023
	§483.80(d)(1) Influenza. The		oolicies		immunizations if applicable,	follow	Status:
	and procedures to ensure that				up based on findings.		APPROVED Date:
	(i) Before offering the influe		resident		- Infection Preventionist or		Date: 05/31/2023
	or the resident's representative regarding the benefits and po		10		Designee will conduct initial	Quality	03/31/2023
	immunization;	otential side effects of th	IC		Improvement (QI) monitorin		
	(ii) Each resident is offered	an influenza immunizati	ion		current residents Pneumococ	-	
	October 1 through March 31		1011		Vaccine history/ documentat		
	immunization is medically c		sident		ensure residents have receive		
	has already been immunized				informed consent and/or		
	(iii) The resident or the resid	lent's representative has	the		administered the pneumococ	ecal	
	opportunity to refuse immur	nization; and			immunization.		
	(iv)The resident's medical re-		tation				
	that indicates, at a minimum	_			- The Director of wellness w		
	(A) That the resident or resident	-			reeducate the Infection Preve		
	provided education regardin		tıal		on facility Pneumococcal Va	iccine	
	side effects of influenza imm	· · · · · · · · · · · · · · · · · · ·			Policy.		
	(B) That the resident either immunization or did not reco				- Infection Preventionist or		
	due to medical contraindicat		ilization		Designee will conduct Quali	tv	
	due to incurcai contraindicat	nons of fotusal.			Improvement (QI) monitorin	-	
	§483.80(d)(2) Pneumococca	ıl disease. The facility m	nust		newly admitted residents	-0 ~-	
	develop policies and proced	-			Pneumococcal Vaccination of	consents	
	(i) Before offering the pneur		, each		weekly x4, then monthly x 3		
	resident or the resident's rep				recommendations will be rep		
	regarding the benefits and pe				Quality Assurance Performa	nce	
	immunization;				Improvement (QAPI)		

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 21 of 25

		identification number		(A2) MOLTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023	
JUNIPER '	VIDER OR SUPPLIER: VILLAGE AT INE-REHABILITATION A		STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
STX4)HDICENSE NUMBERSU2811302 STATEMENT OF DEFICIENCIES (EACH I PREFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0883 SS=D	Continued from page 21 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:		ed or the the tation s	F 0883			

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 22 of 25

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756			<u>uv</u>	05/18/2023	
JUNIPER BROOKLI CARE	VIDER OR SUPPLIER: VILLAGE AT INE-REHABILITATION A		STREET ADDRESS. 1950 CLIFFS STATE COLI	IDE DRIVE LEGE, PA			
STX4)HDICENS PREFIX TAG		OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0883	Continued from page 22			F 0883			
SS=D	Based on review of sel procedures, clinical recinterview, it was determensure residents received immunizations for two immunization concerns. Findings include: The policy entitled "Varant Presidents and potential selections and potential selections and potential selections. Resident immunizations unless the contraindicated, the resimmunized, or they are Center for Disease Contraindicated. The resimmunizations. The resimmunizations. The resimmunizations. The resimulations and the resimmunizations and the resimulations and	cord review, and starmined that the facilitied pneumococcal of five residents reviews (Residents 32 and 2 accinations, accinations, ats," last reviewed on the resident or legal seducation regarding side effects of the are offered pneumonths and eligible based on the control recommendation that indicates that the control recommendation that t	ord education				

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 23 of 25

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		395756				05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, 1950 CLIFFSI STATE COLI	DE DRIVE			
STX4HDICENSE NUMBERS12841302 STATEMENT OF DEFICIENCIES (EACH D PREFIX MUST BE PRECEEDED BY FULL REGULATORY TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0883	Continued from page 23			F 0883			
SS=D	immunization or did not due to medical contraint. Clinical record review facility admitted her or There was no document attempted to obtain an administer the pneumo. Clinical record review facility admitted her or was no documentation obtain an informed compneumococcal immunity. During an interview with control preventionist, of AM it was confirmed the evidence that Residents for or offered pneumococcal immunity.	for Resident 32 revent November 30, 2022 attation that the facility informed consent or coccal immunization for Resident 36 revent September 23, 202 that the facility attends at the facility attends at the facility attends on May 18, 2023, at that there was no docks 32 and 36 were evaluation.	ealed the 2. ty n. ealed the 1. There mpted to ne ction 10:00 cumented aluated				
	28 Pa. Code 201.14(a)	Responsibility of lic	eensee				

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 24 of 25

PRINTED: 7/5/2023 FORM APPROVED 2567-L

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395756		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/18/2023	
NAME OF PROVIDER OR SUPPLIER: JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP CODE: 1950 CLIFFSIDE DRIVE STATE COLLEGE, PA 16801				
S TX4)HD ICENS PREFIX TAG	E NUMBERSI 28\1302 STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0883 SS=D	Continued from page 24			F 0883			
	28 Pa. Code 201.18(b)(1) Management						
	28 Pa. Code 211.12(d)(1)(5) Nursing services						

CMS-2567L RMWP11 IF CONTINUATION SHEET Page 25 of 25



Certified End Page

JUNIPER VILLAGE AT BROOKLINE-REHABILITATION AND SKILLED CARE

STATE LICENSE NUMBER: 281302 SURVEY EXIT DATE: 05/18/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY